

INSTRUCTIONS:

- Type or Print neatly.
- All required questions must be answered completely.
- Submit a \$300.00 fee for each certificate being applied.
- Only checks or money orders are acceptable. Make all checks and money orders payable to Metro Dade County.
- Submit as attachment #1 two (2) letters of credit reference, including one bank where an active account is maintained, covering but not limited to length of association, credit experience, and current credit status. The letters are to be addressed to the Consumer Services Department and dated within 30 days of the date of this application.
- Submit as attachment #2 a detailed statement (balance sheet) of the financial condition of the applicant showing all assets at original cost and all liabilities including assured debts and revenue from all sources. The most recent certified financial statement is preferred. If unavailable, submit a financial statement dated and signed by the preparer.
- Submit as attachment #3 proof that you have obtained the following insurance as the operator of a Non-Emergency Medical Transportation Service with limits of liability as stipulated below:

Public Liability Insurance — in amounts not less than
\$300,000 per occurrence for bodily injury
\$ 50,000 per occurrence for property injury

Automobile Liability Insurance — covering all owned, non-owned and hired vehicles used in connection with the work, in amounts not less than \$100,000 per person and \$300,000 per occurrence for bodily injury and \$50,000 per occurrence of property damage.

Acceptable proof shall consist of a Certificate of Insurance or copy of your Insurance policy stating minimum coverage as required above.

**METROPOLITAN DADE COUNTY
CONSUMER SERVICES DEPARTMENT
PASSENGER TRANSPORTATION
REGULATORY DIVISION**

**APPLICATION FOR NON-EMERGENCY
MEDICAL TRANSPORTATION SERVICES
CERTIFICATE OF CONVENIENCE AND
NECESSITY**

Date _____

1. Number of Certificates requested: _____
NOTE: This application may be used to apply for a single or multiple certificates. A certificate is required for each non-emergency vehicle.

2. IDENTIFICATION OF APPLICANT:

- (A) To be completed if applicant is an individual:

Full Name _____ Date of Birth _____
Social Security Number _____ Phone Number _____
Home Address _____ City _____ State _____ Zip _____

- (B) To be completed if applicant is a partnership or non-corporation association:

Name of Organization _____
Date and location organization formed _____
NAME OF EACH PARTNER % INTEREST DATE OF BIRTH ADDRESS SOCIAL SECURITY #

- (C) To be completed if applicant is a corporation:

Name of Corporation _____ Telephone Number _____
Business Address _____ City _____ State _____ Zip _____
Date and location of incorporation _____
NAME OF EACH OFFICER % INTEREST DATE OF BIRTH ADDRESS SOCIAL SECURITY #

3. CRIMINAL RECORD:

Have you been convicted of any criminal charge(s) within 5 years of the date of this application? In case of Corporation or Partnership applicants, this information is to be provided of all corporate officers and partners. NOTE: fingerprints and photographs are required of each applicant, corporate officer and partner.

NO [] YES [] If yes, complete the following for each conviction:
NAME CONVICTED OF DATE COURT & LOCATION

4. PREVIOUS BUSINESS EXPERIENCE

Are you now or have you within the preceding 5 years been engaged in the transportation business or the provision of non-emergency medical services?

NO [] YES [] If yes, complete the following:
SERVICES PROVIDED LOCATION SERVED AGENCY LICENSED BY

Has your operating authority for these services ever been revoked or suspended?

NO () YES [] If yes, give full details:

5. TRADE NAME

Business trade name to be used _____
(Name on business stationery, markings on vehicles, advertising, etc.)
Proposed vehicle color(s) scheme _____

6. PROPOSED CENTRAL PLACE OF BUSINESS LOCATION IN DADE COUNTY

Address _____ Telephone Number _____

Size of facility in square feet _____

Activities that will be performed at this location _____

7. MANAGEMENT PLAN

Provide information on how the following business functions will be conducted and managed:

(A) Name and experience of proposed General Manager:

(B) Employee and Driver Training Program:

(C) Complaint Handling System:

(D) System for maintenance of business records:

(E) System for handling accident(s) and/or injury:

(F) Telephone communication, including system for providing 24 hour access to the public:

(G) Radio communication system:

(H) Vehicle maintenance system:

(I) System for screening and recording service requests:

8. TRANSPORTATION SERVICE

Proposed service(s) to be provided, include type of passenger(s) to be served:

9. VEHICLE DESIGN

Describe how the vehicle(s) to be operated has been specially designed and equipped to provide non-emergency medical transportation service(s).

10. PUBLIC BENEFITS

List and discuss benefits that will accrue to the public good and interest from the proposed service.

11. PROPOSED SERVICE STANDARDS

(A) Geographic area(s) to be serviced:

(B) Days and hours of operation:

(C) Level of service standards:

(D) Other:

12. PROPOSED RATE(S)

CERTIFICATION:

STATE OF FLORIDA)
COUNTY OF DADE)

ss (Verification by Individual)

Before me, the undersigned authority, this day personally appeared _____ who, being by me the first duly sworn, deposes and says that he is the applicant in the foregoing application, statements made herein and attached hereto are true and correct, grants authority to CSD to verify the information contained herein, understands that Dade County reserves the right to deny this application based upon the misrepresentation, alteration, omission, or incompleteness of material fact, and agrees to comply with all provisions and requirements of Metro-Dade County Code, Chapter 4, Article 3, and the laws of the State of Florida should this application be approved.

Signature of Applicant

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____ 199_____.

NOTARY PUBLIC

SEAL

STATE OF FLORIDA)
COUNTY OF DADE)

ss (Verification by corporation, partnership, or non-corporation association)

Before me, the undersigned authority, this day personally appeared _____ who is (Title) _____, who being by me first duly sworn deposes and says that the statements contained to the foregoing application are true and correct, grants authority to CSD to verify the information contained herein, understands that Dade County reserves the right to deny this application based upon the misrepresentation, alteration, omission, or incompleteness of material fact, and agrees to comply with all provisions and requirements of the Dade County Code, Chapter 4, Article 3, and the laws of the State of Florida should this application be approved.

Signature

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____ 199_____.

NOTARY PUBLIC

SEAL

CORPORATE SEAL